PHYSICAL EXAMINATION: **To be completed and signed by Healthcare Provider**
Can not be completed by a family member.
Varsity athletes must have a physical within six months of participation or after March 1st. Per NCAA rules M.D. or D.O. (NOT a PA or NP) must perform physical for varsity athletes.

Last Name (print above)	First Name	Middle Name	Date of birth (mo./ day / year)	Davidson ID #

Date of Exam:_____________Height:______Weight:_______BMI:_________Pulse:________BP:______________

Has this patient experienced significant (10% or more) weight change over the past year? □ Yes □ No
Please describe____

NCAA requires **ALL** varsity athletes to have a hemoglobin solubility (**sickle cell trait screening**).
The **actual lab report** is required; please attach. Alternatively, a copy of the testing done at birth may be attached.
Varsity Athletes: Sports Medicine may require additional documentation to be completed. Please go to davidsonwildcats.com for further information.

Are there abnormalities? If so, describe in full	NO	YES	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Musculoskeletal			
8. Metobolic / Endocrine			
9 Neuropsychiatric			
10. Skin			

Is there loss or seriously impaired function of any paired organs? □Yes □ No
If **YES,** please explain____

Is student under treatment for any medical or mental health condition? □ Yes □No
If **YES**, please explain ____

History of a **Positive COVID-19 test**? □Yes □ No Date of positive test _______________________

Diet Prescription (please check if applicable): This student requires the following diet prescription. This information will be needed for any possible dietary accommodations.

Dairy-free________ Nut-free: All nuts________ Soy-free:_________ Other: ______________________________
Egg-free_________ Tree nuts_______ Shellfish: ________ ______________________________
Gluten-free_______ Peanuts _______ ______________________________

H: Does this student require an EpiPen? □ Yes □ No
Regular medications – List name and dosage:

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____ _______________________
Signature of Physician / Physician Assistant / Nurse Practitioner (M.D. or D.O. only for varsity athletes) Date

____ _____________ / _____________
Signature of Physician / Physician Assistant / Nurse Practitioner (M.D. or D.O. only for varsity athletes) Telephone Fax Number

____
Office Address City State Zip Code